WISCONSIN DEPARTMENT OF REGULATION & LICENSING



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IN THE MATTER OF THE DISCIPLINARY

PROCEEDINGS AGAINST

: FINAL DECISION AND ORDER

RUTH A. TRUMBLE, R.N., : LS07012512NUR

RESPONDENT. :

[Division of Enforcement Case # 05 NUR 229]

The parties to this action for the purposes of Wis. Stat. § 227.53 are:

Ruth A Trumble, R.N.

108 3rd Street

Centuria, WI 54824

Division of Enforcement

Department of Regulation and Licensing

1400 East Washington Avenue

P.O. Box 8935

Madison, WI 53708-8935

Wisconsin Board of Nursing

Department of Regulation and Licensing

1400 East Washington Avenue

P.O. Box 8935

Madison, WI 53708-8935

PROCEDURAL HISTORY

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter subject to the approval of the Board of Nursing. The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

- 1. Ruth A. Trumble, R.N., Respondent, date of birth July 29, 1957, is licensed by the Wisconsin Board of Nursing as a registered nurse in the state of Wisconsin pursuant to license number 118370, which was first granted November 18 1994.
- 2. Respondent's last address reported to the Department of Regulation and Licensing is 108 3rd Street, Centuria WI 54824.
- 3. Respondent was employed as a registered nurse at Frederic Nursing and Rehabilitation Community (facility), in Frederic, Wisconsin, where on April 13, 2005, Mr. A (78 years of age) was admitted to the facility following right leg surgery to repair fractures of his tibia and fibula.
 - a. Mr. A's incision was closed with staples. Wound checks were ordered to be done each a.m. and p.m. and dressing changes were ordered each a.m.
 - b. Mr. A had a follow up appointment scheduled for May 12 with his orthopedic surgeon.
 - c. Mr. A was confused intermittently.
 - d. Mr. A had an order for 1 or 2 oxycodone PRN (as needed) for pain. During April, he requested and received the medications about once each day. In May, he received the medication once on the 1st, 7th and 8th
 - 4. Mr. A's recovery was proceeding uneventfully, until May 10 at 1:17 a.m. when staff found him on the floor in his

room after he fell out of bed. The staff working the May 9-10 night shift acted appropriately. Because Mr. A's vital signs were stable and he was able to move his extremities with no complaints of pain, they did not remove the bandage to check the wounsite.

- 5. **Respondent** worked the day shift on May 10.
 - a. At 6:45 a.m., she gave Mr. A two oxycodone for right leg pain and noted it as effective. She did not examine Mr. A's wound or assess the cause of the pain.
 - b. She notified Mr. A's legal guardian of the fall.
 - c. At 10:00 a.m., she sent a fax to Mr. A's physician notifying him of a no injury fall and that Mr. A had a scheduled appointment with his orthopedic surgeon for May 12 and requesting an extension of the order for PRN pain medication, which was to expire May 13. The physician extended the order later that day.
 - d. At 1:20 p.m., she gave Mr. A an oxycodone for right leg pain and noted relief at 2:30 p.m. She did not examine Mr. A's wound or assess the cause of the pain.
 - e. Mr. A asked Respondent to send him to the hospital because of the pain, but she declined to do so. Respondent did not examine Mr. A's wound or assess the cause of the pain at any time on that shift.
 - f. She did not perform the wound check or dressing change which was ordered for her shift.
 - g. However, she documented in the treatment book that she did them both. Her taped report to the next shift said she had done them or was going to do them. Respondent contends she did the documentation with the intention that she would do the check and dressing change, but then forgot to do them.
- 6. **Respondent** failed to examine Mr. A's wound or attempt to determine the cause of his pain and failed to carry out a medical order all of which was a substantial departure from the standard of care ordinarily exercised by a competen nurse.
 - 7. LPN A began her shift at 2:00 p.m.:
 - a. **Respondent** told LPN A that Mr. A had requested to be sent to the hospital but that he had an appointment with his orthopedist in two days and should not be sent to the hospital.
 - b. LPN A noted that Mr. A refused to get out of his bed during this shift and said his leg hurt too bad. He continued to complain of pain. When LPN A offered pain medication, he declined it saying that it did not help. He demanded that he be taken to the hospital and have an x-ray because of the pain, but LPN A declined to do so.
 - c. LPN A took his vitals and looked at the outside of his dressing to determine if it was in place. Despite Mr. A's continuing complaints of pain, LPN A did not examine Mr. A's wound or assess the cause of the pain.
 - d. LPN A did not perform the wound check which was ordered for her shift.
- 8. At 5:38 a.m. on May 11, another RN checked the wound and changed the dressing. She reported that the surgical incision healed with a small scab and scant yellow drainage.
 - 9. **Respondent** worked the day shift on May 11.
 - a. At 12:30 p.m., she gave Mr. A an oxycodone for right leg pain and noted some relief.
 - b. She performed the ordered p.m. wound check shortly before 1:00 p.m. and discovered that the stapled area had come apart. There was no swelling and Mr. A was afebrile. She called and reported this to Mr. A's physician.
- 10. At 3:00 p.m., Mr. A was transported to the hospital's emergency department for evaluation. He returned at 5:00 p.m. with additional orders, including the antibiotic Keflex. At 5:52 a.m. on May 12, a wound care note said that the incision line had an open area 12 cm long by 2.5 cm wide by 1 cm deep. Mr. A went to his appointment with the orthopedic surgeon later that morning. Because the incision site had been open overnight, the orthopedic surgeon had Mr. A hospitalized until Mar

CONCLUSIONS OF LAW

- 1. The Wisconsin Board of Nursing has jurisdiction over this matter pursuant to Wis. Stat. § 441.07 and ha authority to enter into this stipulated resolution of this matter pursuant to Wis. Stat. § 227.44(5).
- 2. Respondent, by engaging in the conduct set out above, has committed negligence as defined by Wis. Adm. Cod § N 7.03(1)(c) & (d), which subjects Respondent to discipline pursuant to Wis. Stat. § 441.07(1)(c).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED:

- 1. Respondent, Ruth A. Trumble, R.N., is hereby REPRIMANDED for the above conduct.
- 2. Respondent's license is LIMITED as follows:
- a. Within 120 days of the date of this Order, Respondent shall provide proof sufficient to the Board, or it designee, of Respondent's satisfactory completion of a total of twelve (12) hours of continuing education in the following areas: six (6) hours in patient assessment and six (6) hours in wound care, which courses shall first be approved by the Board, or its designee.
- b. Upon Respondent providing proof sufficient to the Board, or its designee, that she has completed the education, the Board shall issue an Order removing this limitation of Respondent's license.
- 3. Respondent shall, within 120 days of the date of this Order, pay to the Department of Regulation and Licensit costs of this proceeding in the amount of \$455, pursuant to Wis. Stat. § 440.22(2).
- 4. All payments, requests and evidence of completion of the education required by this Order shall be mailed, faxor delivered to:

Department Monitor
Department of Regulation and Licensing
Division of Enforcement
1400 East Washington Ave.
P.O. Box 8935
Madison, WI 53708-8935
Fax (608) 266-2264
Telephone (608) 267-3817

- 5. Violation of any of the terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Board in its discretion may in the alternativ impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order. In the event that Respondent fails to pay costs as ordered or fails to comply with the ordered continuing education, Respondent' license SHALL BE SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of this Order.
 - 6. This Order is effective on the date of its signing.

Wisconsin Board of Nursing

By: Marilyn Kaufmann 1/25/07 A Member of the Board Date

STATE OF WISCONSIN BEFORE THE BOARD OF NURSING

RESI CINDEINI.	•		
RESPONDENT.			
RUTH A TRUMBLE, R.N.,	:	LS	NUR
	:	STIPUI	LATION
PROCEEDINGS AGAINST	:		
IN THE MATTER OF THE DISCIPLINARY	:		

It is hereby stipulated and agreed, by and between Ruth A. Trumble, R.N., Respondent; and John R. Zwieg, attorney for the Complainant, Department of Regulation and Licensing, Division of Enforcement, as follows:

- 1. This Stipulation is entered into as a result of a pending investigation of Respondent's licensure by the Division of Enforcement (file 05 NUR 229). Respondent consents to the resolution of this investigation by stipulation and without the issuance of a formal complaint.
- 2. Respondent understands that by signing this Stipulation, she voluntarily and knowingly waives her rights, including the right to a hearing on the allegations against her, at which time the state has the burden of proving those allegations by a preponderance of the evidence; the right to confront and cross-examine the witnesses against her; the right to call witnesses of her behalf and to compel their attendance by subpoena; the right to testify herself; the right to file objections to any proposed decision and to present briefs or oral arguments to the officials who are to render the final decision; the right to petition for rehearing; and all other applicable rights afforded to her under the United States Constitution, the Wisconsin Constitution, the Wisconsin Statutes, the Wisconsin Administrative Code, and any other provisions of state or federal law.
 - 3. Respondent has been provided an opportunity to obtain advice of legal counsel prior to signing this Stipulation.
- 4. Respondent agrees to the adoption of the attached Final Decision and Order by the Board. The parties to the Stipulation consent to the entry of the attached Final Decision and Order without further notice, pleading, appearance or consent of the parties. Respondent waives all rights to any appeal of the Board's Order, if adopted in the form as attached.
- 5. If the terms of this Stipulation are not acceptable to the Board, the parties shall not be bound by the contents of this Stipulation, and the matter shall be returned to the Division of Enforcement for further proceedings. In the event that this Stipulation is not accepted by the Board, the parties agree not to contend that the Board has been prejudiced or biased in any manner by the consideration of this attempted resolution.
- 6. The parties to this Stipulation agree that the attorney or other agent for the Division of Enforcement and any member of the Board ever assigned as a case advisor in this investigation may appear before the Board in open or closed session, without the presence of the Respondent or her attorney, if any, for purposes of speaking in support of this agreement and answering questions that any member of the Board may have in connection with the Board's deliberations on the Stipulation. Additionally, any such case advisor may vote on whether the Board should accept this Stipulation and issue the attached Final Decision and Order.
- 7. Respondent is informed that should the Board adopt this Stipulation, the Board's Final Decision and Order is a public record and will be published in accordance with standard Department procedure.
- 8. The Division of Enforcement joins Respondent in recommending the Board adopt this Stipulation and issue the attached Final Decision and Order.

Ruth A. Trumble, R.N.	Date	
Respondent		

108 3rd S	treet	
Centuria,	WI	54824

John R. Zwieg
Attorney for Complainant
Division of Enforcement
Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935

Date